U. S. Department of State

MEDICAL EXAMINATION FOR IMMIGRANT OR REFUGEE APPLICANT

For use with TB Technical Instructions 1991 and the DS-3024

OMB No. 1405-0113
EXPIRATION DATE: 04/30/2012
ESTIMATED BURDEN: 10 minutes
(See Page 2 - Back of Form)

Photo

Name *(Last, First, MI.)* _____, _____, _____

Birth Date *(mm-dd-yyyy)* _____ **Sex:** ☐ **M** ☐ **F**

Birthplace *(City/Country)* _____ /_____

Present Country of Residence _____ **Prior Country** _____

U.S. Consul *(City/Country)* _____ /_____

Passport Number _____ **Alien** *(Case)* **Number** _____

Date *(mm-dd-yyyy)* **of Medical Exam** _____ **Date** *(mm-dd-yyyy)* **of Prior Exam, if any** _____

Date Exam Expires *(6 months from examination date, if Class A or TB condition exists, otherwise 12 months) (mm-dd-yyyy)* _____

Exam Place *(City/Country)* _____ /_____ **Panel Physician** _____

Radiology Services _____ **Screening Site** *(name)* _____

Lab *(name for HIV/syphilis/TB)* _____ /_____ /_____

(1) Classification *(check all boxes that apply):*

☐ **No apparent defect, disease, or disability** *(see Worksheets DS-3024, DS-3025 and DS-3026)*

☐ **Class A Conditions** *(From Past Medical History and Physical Examination Worksheets)*

- ☐ TB, active, infectious *(Class A, from Chest X-Ray Worksheet)*
- ☐ Syphilis, untreated
- ☐ Chancroid, untreated
- ☐ Gonorrhea, untreated
- ☐ Granuloma inguinale, untreated
- ☐ Lymphogranuloma venereum, untreated
- ☐ Human immunodeficiency virus (HIV)
- ☐ Hansen's disease, untreated multibacillary
- ☐ Addiction or abuse of specific* substance without harmful behavior
- ☐ Any physical or mental disorder (including other substance-related disorder) with harmful behavior or history of such behavior likely to recur

*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics

☐ **Class B Conditions** *(From Past Medical History and Physical Examination Worksheets)*

- ☐ TB, active, noninfectious *(Class B1, from Chest X-Ray Worksheet)*
  Treatment: ☐ None ☐ Partial ☐ Completed
- ☐ TB, inactive *(Class B2, from Chest X-Ray Worksheet)*
  Treatment: ☐ None ☐ Partial ☐ Completed
  See Section 4 on page 2 for TB treatment details
- ☐ Syphilis *(with residual deficit)*, treated within the last year
- ☐ Other sexually transmitted infections, treated within last year
- ☐ Current pregnancy, number of weeks pregnant _____
- ☐ Other *(specify or give details on checked conditions from worksheets)*
- ☐ Hansen's disease, treated multibacillary
  Treatment: ☐ Partial ☐ Completed
- ☐ Hansen's disease, paucibacillary
  Treatment: ☐ None ☐ Partial ☐ Completed
- ☐ Sustained, full remission of addiction or abuse of specific* substances
- ☐ Any physical or mental disorder (excluding addiction or abuse of specific* substance but including other substance-related disorder) without harmful behavior or history of such behavior unlikely to recur

*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics

_____

_____

_____

(2) Laboratory Findings *(check all boxes that apply):*

Syphilis: ☐ **Not done**

	Test name	Date(s) run *(mm-dd-yyyy)*	Negative	Positive	Titer 1	Notes
Screening			☐	☐		
Confirmatory			☐	☐		

Treated	If treated, therapy:	Date(s) treatment given *(3 doses for penicillin)*
☐ Yes	☐ Benzathine penicillin, 2.4 MU IM	
☐ No	☐ Other *(therapy, dose)*:E	

HIV: ☐ **Not done**

	Test name	Date(s) run *(mm-dd-yyyy)*	Negative	Positive	Indeterminate	Notes
Screening			☐	☐	☐	
Secondary			☐	☐	☐	
Confirmatory			☐	☐	☐	

(3) Immunizations *(See Vaccination Form, check all boxes that apply)* **Not required for refugee applicants.**

☐ Vaccine history complete

☐ Vaccine history incomplete, requesting waiver *(indicate type below)*

☐ Incomplete vaccine history, no waiver requested

☐ Blanket waiver ☐ Individual waiver

I certify that I understand the purpose of the medical examination and I authorize the required tests to be completed.

Applicant Signature _____ Panel Physician Signature _____ Date *(mm-dd-yyyy)* _____

(4) Tuberculosis Treatment Regimen

(Fill out if applicant has taken in the past, or is now taking TB medication. If drug doses or dates not known or not available, mark "unknown".)

☐ Check if therapy currently prescribed *(if current, don't mark "End Date")*

Medication	Dose/Interval *(i.e., mg/day)*	Start Date *(mm-dd-yyyy)*	End Date *(mm-dd-yyyy)*
☐ Isonaizid (INH)			
☐ Rifampin			
☐ Pyrazinamide			
☐ Ethambutol			
☐ Streptomycin			
☐ Other, specify			

Applicant's pre-treatment weight (kg) _____ Date *(mm-dd-yyyy)* _____

Remarks _____

_____

_____

_____

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time required for searching existing data sources, gathering the necessary documentation, providing the information and/or documents required, and reviewing the final collection. You do not have to supply this information unless this collection displays a currently valid OMB control number. If you have comments on the accuracy of this burden estimate and/or recommendations for reducing it, please send them to: A/GIS/DIR, Room 2400 SA-22, U.S. Department of State, Washington, DC 20522-2202

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PURPOSE: The U.S. Department of State uses the facts you provide on this form primarily to determine your classification and eligibility for a U.S. immigrant visa. Individuals who fail to submit this form or who do not provide all the requested information may be denied a U.S. immigrant visa. Although furnishing this information is voluntary, failure to provide this information may delay or prevent the processing of your case.

ROUTINE USES: If you are issued an immigrant visa and are subsequently admitted to the United States as an immigrant, the Department of Homeland Security will use the information on this form to issue you a Permanent Resident Card, and, if you so indicate, the Social Security Administration will use the information to issue a social security number. The information provided may also be released to federal agencies for law enforcement, counterterrorism and homeland security purposes; to Congress and courts within their sphere of jurisdiction; and to other federal agencies who may need the information to administer or enforce U.S. laws.

U.S. Department of State

CHEST X-RAY AND CLASSIFICATION WORKSHEET

For use with TB TI 1991 and the DS-2053

Complete Sections 1 through 5, As Applicable

OMB No. 1405-0113
EXPIRATION DATE: 04/30/2012
ESTIMATED BURDEN: 10 MINUTES
(See Page 2 - Back of Form)

Name *(Last, First, MI.)*	Age

Birth Date *(mm-dd-yyyy)*	Passport Number	Alien (Case) Number

1. Chest X-Ray Indication *(Mark all that apply)*

- ☐ History of Tuberculosis *(TB)* Disease
- ☐ Contact with Person with TB
- ☐ TB Signs or Symptoms
- ☐ Adult *(With or without any of the other indications)*

(If child does not have any of the above, stop here.)

2. Chest X-Ray Findings **Date Chest X-Ray Taken** *(mm-dd-yyyy)* _____

- ☐ Normal Findings
- ☐ Abnormal Findings *(Indicate category and finding, checking all that apply, in the table below.)*

☐ **Can Suggest ACTIVE TB** *(Need smears)*	☐ **Can Suggest INACTIVE TB** *(Need smears if symptomatic)*	☐ **OTHER X-Ray Findings**
☐ Infiltrate or consolidation	☐ Discrete fibrotic scar or linear opacity *(fibrotic scar)*	☐ **Follow-Up Needed** *(Mark as "Class B Other")*
☐ Any cavitary lesion	☐ Discrete nodule*(s)* without calcification	☐ Musculoskeletal
☐ Nodule or mass with poorly defined margins *(such as tuberculoma)*	☐ Discrete linear opacity *(fibrotic scar)* with volume loss or retraction	☐ Cardiac
☐ Pleural effusion*****	☐ Other *(Such as bronchiectasis)*	☐ Pulmonary, non-TB *(e.g., emphysema)*
☐ Hilar/mediastinal adenopathy with or without atelectasis		☐ Other
☐ Other *(Such as miliary findings)*		☐ **No Follow-Up Needed for** Pleural thickening, diaphragmatic tenting, calcified pulmonary nodule*(s)*, calcified lymph node*(s)*, calcified lymph nodes with calcified pulmonary nodule*(s)*, or minor musculoskeletal findings

* If unclear whether pleural fluid or thickening, perform lateral or decubitus chest radiograph, or targeted ultrasound.

Remarks

_____

_____

_____

_____ _____

Radiologist's Signature Date Interpreted *(mm-dd-yyyy)*

3. Sputum Smears

☐ **No, Applicant has No Signs or Symptoms of TB and :**

- ☐ X-Ray Suggests INACTIVE TB, this is a **Class B2/TB**
- ☐ OTHER X-Ray Findings Suggest Follow-Up Needed after Arrival, this is **B Other**
- ☐ OTHER X-Ray Findings Suggest N**o Follow-Up Needed,** this is **No Class**
- ☐ X-Ray Normal, this is **No Class**

☐ **Yes, Applicant has** *(Mark all that apply)* :

	and Smear Results are: Positive	Negative	Dates Obtained *(mm-dd-yyyy)*
☐ Signs or Symptoms of TB, See Section 1	☐	☐	_____
☐ X-Ray Suggests ACTIVE TB, See Section 2	☐	☐	_____
	☐	☐	_____

Sputum Smear Results and X-Ray:
At least One Smear Result POSITIVE and

☐ Any Chest X-Ray Finding *(Normal or Abnormal findings)*, this is **Class A/TB**

Three Smear Results NEGATIVE and

- ☐ X-Ray Normal with
  - ☐ Signs or Symptoms Resolved, this is **No Class**
  - ☐ Signs or Symptoms Suggest Follow-Up Needed after Arrival, this is **B Other**
- ☐ X-Ray Suggests ACTIVE or INACTIVE TB, this is **Class B1/TB**
- ☐ OTHER X-Ray Findings Suggest Follow-Up Needed After Arrival, this is **Class B Other**

4. ☐ **No Class** ☐ **Class A/TB** ☐ **Class B1/TB** ☐ **Class B2/TB** ☐ **Class B Other**

5. Follow-Up Needed After Arrival ☐ No ☐ Yes If Yes, for ☐ Not TB Condition ☐ TB Condition

Remarks *(If non-TB condition, specify condition below **and** on DS-2053 form; include additional tests, and therapy used with start and stop dates and any changes. If TB condition, enter information in Part 4 of DS-2053 form.)*

_____

_____

_____

_____

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

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U.S. Department of State

VACCINATION DOCUMENTATION WORKSHEET

For Use with DS-2053 or DS-2054 — To Be Completed by Panel Physician Only

OMB No. 1405-0113
EXPIRATION DATE: 04/30/2012
ESTIMATED BURDEN: 30 minutes
(See Page 2 of 2)

Name *(Last, First, MI.)*		Exam Date *(mm-dd-yyyy)*
Birth Date *(mm-dd-yyyy)*		Alien (*Case*) Number

REQUIRED FOR U.S. IMMIGRANT VISA APPLICANTS

NOT REQUIRED FOR REFUGEE APPLICANTS

NOTE FOR PANEL PHYSICIANS:
For refugee applicants, please complete only if reliable vaccination documents are available.

1. Immunization Record

Vaccine	Vaccine History Transferred From a Written Record *(List Chronologically from Left to Right)* Date Received *(mm-dd-yyyy)*	Date Received *(mm-dd-yyyy)*	Date Received *(mm-dd-yyyy)*	Date Received *(mm-dd-yyyy)*	Vaccine Given by Panel Physician *(mm-dd-yyyy)*	Completed Series *(✓ if Completed, Write "VH" if Varicella History, or write Date of Lab Test if Immune)*	Blanket Waiver(s) To Be Requested If Vaccination Not Medically Appropriate, Check Suitable Box(es) Below: Not Age Appropriate	Insufficient Time Interval	Contra-indicated	Not Routinely Available	Not Fall *(Flu)* Season
Specify (*check*) vaccine: ☐ DT ☐ DTP ☐ DTaP											
Specify (*check*) vaccine: ☐ Td ☐ Tdap											
Specify (*check*) vaccine: ☐ Polio -OPV ☐ IPV											
Specify (*check*) vaccine: ☐ MMR (Measles-Mumps-Rubella) ☐ Rubella Specify (*check*) vaccine: ☐ Measles ☐ Measles - Rubella Specify (*check*) vaccine: ☐ Mumps ☐ Mumps - Rubella											
Rotavirus											
Hib											
Hepatitis A											
Hepatitis B											
Meningococcal											
Human papillomavirus											
Varicella											
Zoster											
Pneumococcal											
Influenza											

2. Results

☐ Vaccine History Incomplete

☐ Applicant may be eligible for blanket waiver(s) because vaccination(s) not medically appropriate *(as Indicated Above)*.

☐ Applicant will request an individual waiver based on religious or moral convictions.

☐ Vaccine history complete for each vaccine, all requirements met *(Documented Above)*.

☐ Applicant does not meet vaccination requirements for one or more vaccines and no waiver is requested.

3. Panel Physician *(Name)* _____

Panel Physician *(Signature)* _____

Date *(mm-dd-yyyy)* _____

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U.S. Department of State

MEDICAL HISTORY AND PHYSICAL EXAMINATION WORKSHEET

For use with DS-2053 or DS-2054

OMB No. 1405-0113
EXPIRATION DATE: 04/30/2012
ESTIMATED BURDEN: 35 minutes
(See Page 2 - Back of Form)

Name *(Last, First, MI)*		Exam Date *(mm-dd-yyyy)*
Birth Date *(mm-dd-yyyy)*	Passport Number	Alien *(Case)* Number

1. Past Medical History *(indicate conditions requiring medication or other treatment after resettlement and give details in Remarks)*

NOTE: The following history has been reported, has not been verified by a physician, and should not be deemed medically definitive.

No	Yes	
		General
☐	☐	Illness or injury requiring hospitalization *(including psychiatric)*
		Cardiology
☐	☐	Angina pectoris
☐	☐	Hypertension *(high blood pressure)*
☐	☐	Cardiac arrhythmia
☐	☐	Congenital heart disease
		Pulmonology
☐	☐	History of tobacco use Current use ☐ Yes ☐ No
☐	☐	Asthma
☐	☐	Chronic obstructive pulmonary disease *(emphysema)*
☐	☐	History of tuberculosis *(TB)* disease Treated ☐ Yes ☐ No Current TB symptoms ☐ Yes ☐ No
		Neurology and Psychiatry
☐	☐	History of stroke, with current impairment
☐	☐	Seizure disorder
☐	☐	Major impairment in learning, intelligence, self care, memory, or communication
☐	☐	Major mental disorder *(including major depression, bipolar disorder, schizophrenia, mental retardation)*
☐	☐	Use of drugs other than those required for medical reasons
☐	☐	Addiction or abuse of specific* substance *(drug)* *amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics
☐	☐	Other substance-related disorders *(including alcohol addiction or abuse)*
☐	☐	Ever taken action to end your life

No	Yes	
☐	☐	Ever caused SERIOUS injury to others, caused MAJOR property damage or had trouble with the law because of medical condition, mental disorder, or influence of alcohol or drugs
		Obstetrics and Sexually Transmitted Diseases
☐	☐	Pregnancy Fundal height _____ cm Last menstrual period Date *(mm-dd-yyyy)* _____
☐	☐	Sexually transmitted diseases, specify _____
		Endocrinology and Hematology
☐	☐	Diabetes mellitus
☐	☐	Thyroid disease
☐	☐	History of malaria
		Other
☐	☐	Malignancy, specify _____
☐	☐	Chronic renal disease
☐	☐	Chronic hepatitis or other chronic liver disease
☐	☐	Hansen's Disease ☐ Multibacillary ☐ Paucibacillary Treated ☐ Yes ☐ No
☐	☐	Visible disabilities *(including loss of arms or legs)*, specify
☐	☐	Other requiring treatment, specify

2. Physical Examination *(indicate findings and give details in Remarks)*

☐ No ☐ Yes Applicant appears to be providing unreliable or false information, specify

Height _____ cm Weight _____ kg Visual Acuity at 20 feet: Uncorrected L 20/ _____ R 20/ _____

BP ____ / ____ *(mmHg)* Heart rate _____ /min Respiratory rate ____ /min Corrected L 20/ _____ R 20/ _____

***N, normal; A, abnormal; ND, not done**

N*	A*	ND*	
☐	☐	☐	General appearance and nutritional status
☐	☐	☐	Hearing and ears
☐	☐	☐	Eyes
☐	☐	☐	Nose, mouth, and throat *(include dental)*
☐	☐	☐	Heart *(S1, S2, murmur, rub)*
☐	☐	☐	Breast
☐	☐	☐	Lungs
☐	☐	☐	Abdomen *(including liver, spleen)*
☐	☐	☐	Genitalia *(including circumcision, infection(s))*

N*	A*	ND*	
☐	☐	☐	Inguinal region *(including adenopathy)*
☐	☐	☐	Extremities *(including pulses, edema)*
☐	☐	☐	Musculoskeletal system *(including gait)*
☐	☐	☐	Skin *(including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections)*
☐	☐	☐	Lymph nodes
☐	☐	☐	Nervous system *(including nerve enlargement)*
☐	☐	☐	Mental status *(including mood, intelligence, perception, thought processes, and behavior during examination)*

3. Additional Testing Needed Prior to Approving Medical Clearance

No Yes

☐ ☐ Physical examination or laboratory results contradict medical history

☐ ☐ Referral prior to departure If yes, provide results _____

_____

_____

☐ ☐ Referral prior to departure If yes, provide results _____

_____

_____

4. Follow-up Needed After Arrival

☐ No ☐ Yes, within 1 week ☐ Yes, within 1 month ☐ Yes, within 6 months

☐ For continuing medication, list type, dose, and frequency *(Exception: For TB medications, use Part 4 of DS-2053 or DS-2054 form)* _____

_____

☐ For continuing other treatment, specify _____

_____

5. Remarks *(Describe any abnormal history, abnormal findings, and resulting interventions)*

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